FOR OHF USE

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2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041798

Facility Name: HEARTLAND HLTH CR CTR-CANTON

Address: 2081 North Main (Number) Canton (City) 61520 (Zip Code)

County: Fulton

Telephone Number: (309) 647-6135 **Fax #** (309) 647-6141

IDPA ID Number: 344402510002

Date of Initial License for Current Owners: 09-19-88

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Dekany, CPA **Telephone Number:** (419) 252-5740

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Barry Lazarus

(Title) Vice President of Reimbursement

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	82	Skilled (SNF)	82	29,930	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	16	Sheltered Care (SC)	16	5,840	5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	91	3,095	4,538	7,724	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD	6,294	9,163	620	16,077	11
12	SC					12
13	DD 16 OR LESS		2,046		2,046	13
14	TOTALS	6,385	14,304	5,158	25,847	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 72.26%

D. How many bed-hold days during this year were paid by Public Aid?
1 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/26/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 01/01/83 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 82 and days of care provided 4,221

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	116,809	10,134	9,880	136,823	1,263	138,086		138,086			1
2	Food Purchase		130,241		130,241		130,241	(2,840)	127,401			2
3	Housekeeping	77,280	11,943	2,128	91,351		91,351		91,351			3
4	Laundry	32,718	8,242	575	41,535		41,535		41,535			4
5	Heat and Other Utilities			92,487	92,487	4,604	97,091	(3,915)	93,176			5
6	Maintenance	34,201	12,279	44,089	90,569		90,569		90,569			6
7	Other (specify):*			569	569		569		569			7
8	**TOTAL General Services**	261,008	172,839	149,728	583,575	5,867	589,442	(6,755)	582,687			8
	B. Health Care and Programs											
9	Medical Director			14,400	14,400		14,400		14,400			9
10	Nursing and Medical Records	1,106,008	95,744	28,249	1,230,001	27,161	1,257,162	(7,349)	1,249,813			10
10a	Therapy	202,534	2,766	6,708	212,008		212,008		212,008			10a
11	Activities	41,581	4,411	1,920	47,912		47,912		47,912			11
12	Social Services	54,432	136	1,003	55,571		55,571		55,571			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,404,555	103,057	52,280	1,559,892	27,161	1,587,053	(7,349)	1,579,704			16
	C. General Administration											
17	Administrative	77,905		221,259	299,164	(80,268)	218,896		218,896			17
18	Directors Fees											18
19	Professional Services			2,637	2,637	(2,637)						19
20	Dues, Fees, Subscriptions & Promotions			77,602	77,602		77,602	(69,657)	7,945			20
21	Clerical & General Office Expenses	98,577	33,332	47,254	179,163	2,637	181,800	(20,250)	161,550			21
22	Employee Benefits & Payroll Taxes			344,384	344,384	30,638	375,022		375,022			22
23	Inservice Training & Education			535	535		535		535			23
24	Travel and Seminar			18,139	18,139		18,139		18,139			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			93,588	93,588		93,588		93,588			26
27	Other (specify):*			732	732		732	(732)				27
28	**TOTAL General Administration**	176,482	33,332	806,130	1,015,944	(49,630)	966,314	(90,639)	875,675			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,842,045	309,228	1,008,138	3,159,411	(16,602)	3,142,809	(104,743)	3,038,066			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON #0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			195,490	195,490	16,602	212,092		212,092			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			4,161	4,161		4,161	(15)	4,146			32
33	Real Estate Taxes			57,972	57,972		57,972	260	58,232			33
34	Rent-Facility & Grounds			70,733	70,733		70,733		70,733			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			328,356	328,356	16,602	344,958	245	345,203			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		197,662	11,923	209,585		209,585		209,585			39
40	Barber and Beauty Shops			9,174	9,174		9,174		9,174			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			44,895	44,895		44,895		44,895			42
43	Other (specify):*		32,188		32,188		32,188		32,188			43
44	**TOTAL Special Cost Centers**		229,850	65,992	295,842		295,842		295,842			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,842,045	539,078	1,402,486	3,783,609		3,783,609	(104,498)	3,679,111			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,840)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,915)	5		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(15)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,364)	21		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(167)	21		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(1,036)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(17,683)	21		24
25	Fund Raising, Advertising and Promotional	(69,657)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	260	33		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,081)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (104,498)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (104,498)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

HEARTLAND HLTH CR CTR-CANTON

ID# 0041798

Report Period Beginning: 01/01/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Ambulance	$ (7,349)	10	1
2	Personal Purchase	(732)	27	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,081)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,840)	0	0	0	0	0	0	0	0	0	0	(2,840)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(3,915)	0	0	0	0	0	0	0	0	0	0	(3,915)	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,755)	0	0	0	0	0	0	0	0	0	0	(6,755)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(7,349)	0	0	0	0	0	0	0	0	0	0	(7,349)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(7,349)	0	0	0	0	0	0	0	0	0	0	(7,349)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	(69,657)	0	0	0	0	0	0	0	0	0	0	(69,657)	20
21	Clerical & General Office Expenses	(20,250)	0	0	0	0	0	0	0	0	0	0	(20,250)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	(732)	0	0	0	0	0	0	0	0	0	0	(732)	27
28	**TOTAL General Administration**	(90,639)	0	0	0	0	0	0	0	0	0	0	(90,639)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(104,743)	0	0	0	0	0	0	0	0	0	0	(104,743)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(15)	0	0	0	0	0	0	0	0	0	0	(15)	32
33	Real Estate Taxes	260	0	0	0	0	0	0	0	0	0	0	260	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	245	0	0	0	0	0	0	0	0	0	0	245	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(104,498)	0	0	0	0	0	0	0	0	0	0	(104,498)	45

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Manor Care, Inc	100	Health Care & Retirement Corporation of America (See H.O. Cost Report)	Toledo, OH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	See	Home Office Allocation	$ 221,259	HCR Manor Care, Inc	100.00%	$ 221,259	$	1
2	V	Page							2
3	V	8							3
4	V								4
5	V								5
6	V	10a	Therapy Management	6,039	Heartland Management Services	100.00%	6,039		6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 227,298			$ 227,298	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: HCR Manor Care, Inc
Street Address: 333 North Summit St
City / State / Zip Code: Toledo, OH 43604
Phone Number: (419) 252-5500
Fax Number: (419) 329-7731

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	$	$		$ 0	1
2	1	Dietary - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	940,169	509,589	3,844,197	1,263	2
3	5	Utilities - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	288,728		3,844,197	462	3
4	5	Utilities - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	3,082,391		3,844,197	4,142	4
5	10	Nursing - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	11,758,547	7,451,541	3,844,197	18,811	5
6	10	Nursing - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	6,213,378	3,630,890	3,844,197	8,350	6
7	17	General & Admin - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	17,137,345	15,146,077	3,844,197	27,416	7
8	17	General & Admin - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	84,513,196	36,356,102	3,844,197	113,575	8
9	22	Employee Benefits - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac	4,283,731		3,844,197	6,853	9
10	22	Employee Benefits - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	17,698,741		3,844,197	23,785	10
11	30	Depreciation - Direct	Accumulated Cost	2,402,993,349	369 Nurs Fac			3,844,197	0	11
12	30	Depreciation - Pooled	Accumulated Cost	2,860,540,914	369 Nurs Fac	12,354,014		3,844,197	16,602	12
13										13
14	32	Interest				11,412,188				14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 169,682,428	$ 63,094,199		$ 221,259	25

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Bank of America*		X	Finance Capital Additions	N/A		$ 81,675	$			$ 525	1
2	* Note was paid off during the year.											2
3	National City Bank, Trustee		X	Finance Capital Additions	N/A			81,675			3,636	3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$ 81,675	$ 81,675			$ 4,161	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 81,675	$ 81,675			$ 4,161	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** N/A **Line #**

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	57,712	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	57,972	2
3. Under or (over) accrual (line 2 minus line 1).	$	260	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	57,972	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	58,231	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1998	52,938	8
1999	53,687	9
2000	55,103	10
2001	56,741	11
2002	57,972	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HEARTLAND HLTH CR CTR-CANTON COUNTY Fulton

FACILITY IDPH LICENSE NUMBER 0041798

CONTACT PERSON REGARDING THIS REPORT Craig Dekany

TELEPHONE (419) 252-5740 FAX #: (419) 254-5495

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-08-15-205-007	See Attached	$ 28,985.76	$ 28,985.76
2.	09-08-15-205-007	See Attached	$ 28,985.76	$ 28,985.76
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 57,971.52	$ 57,971.52

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 26,529 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1988	$ 55,973	1
2					2
3	TOTALS			$ 55,973	3

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1988	1988	$ 1,936,360	$ 63,080		$ 63,080	$	$ 1,010,027	4
5				1994	8,975	598		598		5,485	5
6	AUDIT ADJ 7/1/03 (#1)			2003	(1,508)	(50)		(50)		(762)	6
7											7
8											8
	Improvement Type**										
9	Land Improvements (Current Year Depreciation)					80,486		80,486		518,218	9
10	Site Work			1988	125,431						10
11	Sewer & Water Lines			1988	85,093						11
12	Paving			1988	82,940						12
13	Yew Trees			1991	4,440						13
14	Landscaping - Stone Wall			1992	3,812						14
15	Drain Tiles and Catch Basins			1992	7,550						15
16	Fire Rated Door - Staff Development			1992	2,444						16
17	Plumbing - Mixing Valve			1992	676						17
18	Carpeting			1992	5,804						18
19	Renovation (Moved from CIP in 1995)			1993	5,360						19
20	Electrical (Moved from CIP in 1995)			1993	1,748						20
21	Carpet Vestibule Lounge - AUDIT ADJ 7/1/03 (#4) - CHG YEAR			1992	5,804						21
22	Aluminum Awning			1993	1,376						22
23	Wood Fence for Courtyard			1993	1,785						23
24	Replace Sod			1993	2,575						24
25	Seal & Stripe Parking Lot			1994	7,564						25
26	Painting			1994	994						26
27	Interior DR Remodel, Carpentry			1994	8,650						27
28	Elec, Plumb, DR Remodel			1994	5,130						28
29	Sprinkler Sys			1994	1,193						29
30	Carpet Lobby, Offices, Nurses Station			1994	13,908						30
31	Concrete Sidewalk			1995	4,440						31
32	Fencing			1995	1,732						32
33	Vinyl Flooring			1995	949						33
34	Electrical			1995	1,154						34
35	Cabinets in Alzheimers Unit			1995	1,394						35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Building Improvements (Current Year Depreciation)		$	$		$	$	$	37
38	Counter Top	1995	244						38
39	Doors	1995	7,346						39
40	Architectural Fees A/L Lounge Renovation	1995	2,231						40
41	Carpet	1996	181						41
42	Painting	1996	1,750						42
43	Painting	1996	1,806						43
44	Labor, Material, Permits to Renovate A/L Lounge	1996	5,615						44
45	Carpeting	1996	1,060						45
46	(51) Doors	1996	8,278						46
47	Grilles for Sliding Glass Door for A/L Lounge	1996	181						47
48	Electrical Engineering and Architectural Service Fees-CHG YR	1995	9,766						48
49	Ceramic Tile	1996	3,511						49
50	Painting	1997	148						50
51	Architectural Services	1997	375						51
52	Architectural Services -Alzheimers Unit	1997	2,075						52
53	Additional Architectural Services	1997	500						53
54	Architectural Services - Alzheimers Unit	1997	575						54
55	Credit on BLD IMP- CNCLD Retainer	1997	(18)						55
56	Addl't HVAC Cost	1997	232						56
57	Credit on Land Imp-CNCLD Retainer	1997	(755)						57
58	Architectural Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	3,725						58
59	Engineering Services - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	250						59
60	Construction Overhead and Interest-AUDIT ADJ 7/1/03 (#7) CHG	1997	18,034						60
61	HVAC - AUDIT AJD 7/1/03 (#7) CHG YEAR	1997	194,747						61
62	HVAC	1998	35,458						62
63	Lift Station - AUDIT ADJ 7/1/03 (#7) CHG YEAR	1997	25,000						63
64	Design Fees For Alzheimers Unit	1998	1,050						64
65	A/C DESIGN & INSTALLATION	1998	36,185						65
66	AA ON ROOFTOP UNIT	1998	7,360						66
67	ROOF TOP UNIT	1998	11,100						67
68	FACIA BOARD & GUTTERS	1998	13,000						68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,718,784	$ 144,114		$ 144,114	$	$ 1,532,968	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,718,784	$ 144,114		$ 144,114	$	$ 1,532,968	1
2	DESIGN FEES FOR ALZHEIMERS UNIT	1999	(1,050)						2
3	WALLCOVERINGS	1999	5,319						3
4	CONSTRUCTION OVERHEAD	1999	11,221						4
5	WALLCOVERINGS	1999	4,097						5
6	SECURE CARE LOCKING SYSTEM	1999	5,101						6
7	PARTITIONS	1999	738						7
8	WALLCOVERINGS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	1,233						8
9	Asphalt Paving	1998	17,441						9
10	CORNER GUARDS-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	251						10
11	COVE BASE-AUDIT ADJ 7/1/03 (#10) CHG YEAR	1999	539						11
12	LOREN COOK ROOF EXHAUST-AUDIT ADJ 7/1/03 (#10) CHG	1999	1,325						12
13	WALL VINYL COVERING	1999	1,936						13
14	CABINETS & TOPS	1999	5,247						14
15	PAINTING	1999	1,450						15
16	PAINTING	1999	17,000						16
17	FLOORING - COVE BASE	1999	1,258						17
18	CUSTOM CABINETS	1999	5,820						18
19	PAINTING	1999	15,000						19
20	INSTALL HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,475						20
21	INSTALL DAMPER HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	643						21
22	INSTALL RTU HVAC-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	1,200						22
23	CEILING INSTALLATION-AUDIT ADJ 7/1/03 (#12) CHG YEAR	1998	10,367						23
24	WALLCOVERING	1999	132						24
25	WALLCOVERING	1999	116						25
26	WALLCOVERING	1999	496						26
27	COOLER	1999	1,245						27
28	WALLCOVERING	1999	744						28
29	PAINTING	1999	33,450						29
30	CABINETRY & COUNTERTOPS	1999	11,067						30
31	CARPETING & FLOORING	1999	1,258						31
32	HVAC	1999	3,318						32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,878,222	$ 144,114		$ 144,114	$	$ 1,532,968	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,878,222	$ 144,114		$ 144,114	$	$ 1,532,968	1
2	CEILING INSTALLATION	1999	10,367						2
3	FLOORING	2000	24,374						3
4	CONSTRUCTION OVERHEAD AND INTEREST	2000	31,653						4
5	DOOR HOLDERS	2000	1,623						5
6	FLOOR COVERING	2000	1,495						6
7	DRY SPRINKLER SYSTEM	2000	1,381						7
8	DRYWALL	2000	6,160						8
9	FREIGHT ON FABRIC	2001	534						9
10	FURNISH & INSTALL HANDRAILS	2001	943						10
11	DOORS	2001	4,200						11
12	ROOF	2001	13,000						12
13	RESIDENT ROOM PAINTING	2002	4,484						13
14	RESIDENT ROOM PAINTING	2002	38,492						14
15	COVE BASE	2001	5,885						15
16	DOORS	2002	3,225						16
17	GENERAL CONSTRUCTION	2002	9,542						17
18	RENOVATION ELECTRICAL-AUDIT ADJ 7/1/03 (#24) CHG YR	2002	61,600						18
19	STAINLESS STEEL VWC	2002	9,059						19
20	STAINLESS STEEL VWC	2002	1,007						20
21	GENERAL CONSTRUCTION	2003	3,994						21
22	ROOF	2003	17,781						22
23	ROOF	2003	970						23
24	ROOFING & SHEET METAL	2003	53,562						24
25	OVERHEAD & INTEREST	2003	8,586						25
26	CARPET AND INSTALL	2003	22,469						26
27	PAVING	2003	72,546						27
28	AUDIT ADJ 7/1/03 (#2) - PG 12 LINE 15 + PG12A, LINE 57	2003	(45)	(2)		(2)		(20)	28
29	AUDIT ADJ 7/1/03 (#3) - PG 12, LINE 18	2003	(5,804)					(5,804)	29
30	AUDIT ADJ 7/1/03 (#5) - PG 12A LINE 47 + PG 12A LINE 55	2003	(2)					(2)	30
31	AUDIT ADJ 7/1/03 (#8) - PG 12B, LINE 4	2003	(11,221)	(561)		(561)		(2,758)	31
32	AUDIT ADJ 7/1/03 (#9) - PG 12B, LINE 5	2003	(225)	(45)		(45)		(218)	32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,269,858	$ 143,506		$ 143,506	$	$ 1,524,166	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,269,858	$ 143,506		$ 143,506	$	$ 1,524,166	1
2	AUDIT ADJ 7/1/03 (#11) - PG 12B, LINE 16	2003	(17,000)	(850)		(850)		(3,825)	2
3	AUDIT ADJ 7/1/03 (#13) - PG 12B, LINE 23	2003	(10,367)	(518)		(518)		(2,333)	3
4	AUDIT ADJ 7/1/03 (#14) - PG 12B, LINE 27	2003	(1,245)	(62)		(62)		(249)	4
5	AUDIT ADJ 7/1/03 (#15) - PG 12B, LINE 28	2003	(744)	(74)		(74)		(335)	5
6	AUDIT ADJ 7/1/03 (#16) - PG 12B, LINE 29	2003	(33,450)	(6,690)		(6,690)		(30,105)	6
7	AUDIT ADJ 7/1/03 (#17) - PG 12B, LINE 30	2003	(11,067)	(553)		(553)		(2,490)	7
8	AUDIT ADJ 7/1/03 (#18) - PG 12B, LINE 31	2003	(1,258)	(252)		(252)		(1,133)	8
9	AUDIT ADJ 7/1/03 (#19) - PG 12B, LINE 32	2003	(3,318)	(166)		(166)		(746)	9
10	AUDIT ADJ 7/1/03 (#20) - PG 12C, LINE 2	2003	(10,367)	(518)		(518)		(2,333)	10
11	AUDIT ADJ 7/1/03 (#21) - PG 12C, LINE 4	2003	(31,653)	(1,583)		(1,583)		(5,803)	11
12	AUDIT ADJ 7/1/03 (#22) - PG 12C, LINE 14	2003	(2,814)	(563)		(563)		(1,079)	12
13	AUDIT ADJ 7/1/03 (#23) - PG 12C, LINE 18 (ASSET #20239)	2003	(2,284)	(209)		(209)		(209)	13
14	AUDIT ADJ 7/1/03 (#25) - PG 12C, LINE 21 (ASSET #20246)	2003	(3,994)	(300)		(300)		(300)	14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,140,297	$ 131,168		$ 131,168	$	$ 1,473,226	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 894,154	$ 64,323	$ 64,323	$		$ 714,388	71
72	Current Year Purchases	68,123						72
73	Fully Depreciated Assets							73
74	H/O ALLOCATION			16,602	16,602			74
75	TOTALS	$ 962,277	$ 64,323	$ 80,925	$ 16,602		$ 714,388	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,158,547	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 195,491	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 212,093	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 16,602	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,187,614	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92			92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. [ ] YES [X] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:	N/A			$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO
16. Rental Amount for movable equipment: $ 70,733 Description: O2 Concentrators, Wheelchairs, Gerichairs, Electric Beds, Etc.
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	N/A		$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	10a	3483 hrs	$ 90,093	118	$ 2,962	$ 482	3,601	$ 93,537	1
2	Licensed Speech and Language Development Therapist	10a	1619 hrs	41,876	42	1,038		1,661	42,914	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a	27277 hrs	70,565	108	2,708	2,284	27,385	75,557	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39	# of prescrpts				197,662		197,662	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): P/S - X-Ray, Lab					11,923			11,923	13
14	TOTAL			$ 202,534	268	$ 18,631	$ 200,428	32,647	$ 421,593	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON **#** 0041798 **Report Period Beginning:** 01/01/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 7,881	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (37,590))	276,686		3
4	Supply Inventory (priced at)	17,787		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	141		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 302,495	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	55,973		13
14	Buildings, at Historical Cost	3,140,298		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	962,277		16
17	Accumulated Depreciation (book methods)	(2,187,615)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,970,933	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,273,428	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 15,325	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	157,267		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	57,972		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Accrued Expenses	34,467		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 265,031	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	81,675		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 81,675	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 346,706	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,926,722	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,273,428	$	48

***(See instructions.)**

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,994,044	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,994,044	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	268,431	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 268,431	17
	B. Transfers (Itemize):		
18	**Change in Interdivision**	(335,753)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (335,753)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,926,722	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,652,769	1
2	Discounts and Allowances for all Levels	(637,358)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,015,411	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	780,565	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 780,565	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	1,084	12
13	Barber and Beauty Care	12,709	13
14	Non-Patient Meals	1,921	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	201,826	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	33,540	19
20	Radiology and X-Ray	3,244	20
21	Other Medical Services	1,725	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 256,049	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	15	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 15	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,052,040	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	583,575	31
32	Health Care	1,559,892	32
33	General Administration	1,015,944	33
	B. Capital Expense		
34	Ownership	328,356	34
	C. Ancillary Expense		
35	Special Cost Centers	295,842	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,783,609	40
41	**Income before Income Taxes (line 30 minus line 40)****	268,431	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 268,431	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,916	2,078	$ 50,340	$ 24.23	1
2	Assistant Director of Nursing	3,344	3,626	66,598	18.37	2
3	Registered Nurses	11,693	12,681	222,816	17.57	3
4	Licensed Practical Nurses	14,598	15,831	239,023	15.10	4
5	Nurse Aides & Orderlies	51,934	56,320	516,303	9.17	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	7,384	7,828	202,534	25.87	7
8	Rehab/Therapy Aides					8
9	Activity Director					9
10	Activity Assistants	3,941	4,282	41,581	9.71	10
11	Social Service Workers	3,529	3,833	54,432	14.20	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,602	16,957	116,809	6.89	15
16	Dishwashers					16
17	Maintenance Workers	1,883	2,048	34,201	16.70	17
18	Housekeepers	8,978	9,759	77,280	7.92	18
19	Laundry	4,788	5,203	32,718	6.29	19
20	Administrator	3,051	3,051	77,905	25.53	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,264	7,381	98,577	13.36	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,304	1,416	10,928	7.72	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	140,209	152,294	$ 1,842,045 *	$ 12.10	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	14,400	Line9Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 14,400		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Betty Arnold	Administrator	0	$ 19,476
Melissa Pate	Administrator	0	58,429
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 77,905

B. Administrative - Other

Description	Amount
Home Office	$ 221,259
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 221,259

C. Professional Services

Vendor/Payee	Type	Amount
The Weissman Group	Consulting Fees	$ 2,637
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 2,637

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 50,473
Unemployment Compensation Insurance	17,711
FICA Taxes	128,951
Employee Health Insurance	135,232
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Benefits	3,168
Payroll Overhead Allocated	0
401K	6,420
Tuition Program	405
Employee Uniforms	2,024
Home Office Allocation	30,638
TOTAL (agree to Schedule V, line 22, col.8)	$ 375,022

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 455
Advertising: Employee Recruitment	1,535
Health Care Worker Background Check	
(Indicate # of checks performed 27)	538
Dues and Subscriptions	744
Association Dues	4,572
Advertising	69,758
Less: Non-allowable association dues	(1,378)
Less: Public Relations Expense	( )
Non-allowable advertising	(68,279)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,945

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	16,884
Includes travel expense to the Home Office in Toledo, OH for regional Meeting	
Seminar Expense	1,255
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 18,139

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number HEARTLAND HLTH CR CTR-CANTON # 0041798 Report Period Beginning: 01/01/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $ 4,572**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period?

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **25,655** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **44,895**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **1,921**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.